Clinic Director and Principal Psychologist
Dr Alissa Knight
PhD (Psychology)
M.Psych (Clinical)
B.Psych (Hons)
M.Journalism & Mass Communication
B.ED (Junior Primary/Primary)

Specialising in Treatment of Mental Health Conditions
Female Youth (12 – 35 years)

Referral Form – Eating Disorder (early intervention)

To be completed by a registered General Practitioner, Psychiatrist, or other relevant Health Professional. Please consider if the patient is eligible for an Eating Disorders Treatment Plan through Medicare. Referrer to please complete form to Dr Alissa Knight by Email **info@thecalmingsuite.com.au**

Date of Referral:	

Client Details

Name:		Gender:	
DOB:		Client Phone:	
Address:			
Email address:			
Emergency Contact Name and Phone Number:		Phone:	
Who is the best person to contact regarding this referral?	☐ Young person ☐ Parent/guardian ☐ Referrer		
Does the client identify as an Aboriginal and/or Torres Strait Islander or of a Culturally and Linguistically Diverse background?	☐ Yes ☐ No ☐ Yes ☐ No		
Is an Interpreter required, if so which language?			
If the young person is aged under 16, is the parent or carer aware of the referral?	☐ Yes ☐ No		

Referrer Details

Name:		Phone:		Fax:	
Organisation:					
Email address:					
Relationship to young person:					

Consent for Referral

I, _____ [young person], agree to be referred to **Dr Alissa Knight** at **The Calming Suite**

And give my permission for _____ [Referrer's Full Name] to provide/receive written and verbal information to/from **Dr Alissa Knight** for the purpose of facilitating this referral.

Client signature: _____ *Date:* _____

What has led to referring the young individual to Dr Alissa Knight for Eating Disorder Treatment?
What are the current Eating Disorder presenting issues?

Eating Disorder Behaviours			Comments/Frequency
Restricting food intake	☐	Body Image Concerns ☐	
Binge Eating	☐	Amenorrhea ☐	
Vomiting	☐	Other: ☐	
Laxatives	☐	☐	
Excessive Exercise	☐	☐	
Perfectionism	☐	☐	

Is the young individual a current inpatient? ☐ Yes ☐ No If Yes, where: _____

Eating Disorder Treatment History

	Date (indicate if still current)	Comments
Hospital inpatient ☐ Yes ☐ No		
Medical Outpatient (e.g., paediatrician) ☐ Yes ☐ No		
Psychologist ☐ Yes ☐ No		
Psychiatrist ☐ Yes ☐ No		
Dietician/Other ☐ Yes ☐ No		

Weight History

Current Weight _____ Kg Height _____ m BMI (kg ÷ m ÷ m) _____
Largest Weight _____ Kg When _____ Lowest Weight _____ When _____
Weight changes in the last 6 months _____

Medical Assessment (Please undertake a medical examination of the patient)

	Observation	Comments
1. BMI (at least ≥16)	☐ Yes ☐ No	
2. Weight loss (>0.5 for several weeks)	☐ Yes ☐ No	
3. Systolic Blood Pressure ≥90	☐ Yes ☐ No	
4. HR >50	☐ Yes ☐ No	
5. Normal ECG	☐ Yes ☐ No	
6. Normal Electrolytes	☐ Yes ☐ No	
7. Current or high risk of medical complications due to ED	☐ Yes ☐ No	
8. Has an ED based on DSM-5 criteria (if so, indicate whether AN, Atypical AN, BN, BED or other)	☐ Yes ☐ No	

Based on the client's current presentation please consider whether the client is suitable for early intervention outpatient ED treatment (illness duration ≤ 3 years) with Dr Alissa Knight (requires YES to criteria 1,3,4,7,8 – criteria 2,5,6 not required but will further strengthen suitability)

☐ Yes ☐ No

If the client does not meet this criteria, and present as high to imminent risk, please consider the following two options:

Statewide Eating Disorder Service (SEDS). For youth presenting with severe AN symptomatology (i.e., BMI 13 - 16) SEDS offer a 4-day inpatient program.

Hospital Inpatient Treatment. For youth presenting with extreme AN symptomatology (i.e., BMI <13) the proposed service will work in conjunction with the Flinders Medical Centre Eating Disorder Unit (FMC ED) and the Woman's and Children's Hospital to assist those individuals requiring intensive, lifesaving recovery support (i.e., psychiatric and refeeding care) to prevent death, further weight loss, treat medical complications, supplement nutritional deficits.

Please indicate if any of the following issues are other areas the young individual requires support with:

Homeless or at risk of homelessness	☐	Trauma	☐
Pregnancy/young parent	☐	Alcohol and drugs	☐
Family issues	☐	Work and Education options	☐
School/Academic issues	☐	Body Image Concerns	☐
Gender/Sexuality	☐	Sleep	☐
Perfectionism	☐	Low Self-Esteem	☐

Please indicate if the client has any comorbid Mental Health Conditions you consider the young individual requires support with:

Anxiety	☐	Bipolar Disorder (Type II)	☐
Depression	☐	Borderline Personality Disorder	☐
Trauma/PTSD	☐	Psychosis	☐
OCD	☐	ASD	☐
Intellectual Disability	☐	ADHD	☐

Please Note: mental health assessment and/or therapy for ASD, ADHD and Intellectual Disabilities are not currently provided by Dr Alissa Knight at The Calming Suite. Please consider specialists in these areas.

Risk

If you are concerned about this individual's risk to themselves or others, please indicate how:

Tick each of the following options.

Is the young person currently having thoughts of suicide that you are aware of? ☐ Yes ☐ No

Does the young person have a current plan to end their life that you are aware of? ☐ Yes ☐ No

Does the young person have a history of suicide attempts or self-harm that you are aware of? ☐ Yes ☐ No

GP details				
Does the client have an existing GP?		☐ Yes ☐ No *If yes, please provide details below.*		
GP Name:		Phone:		Fax:
GP practice location/address:				

GP Review Requirements

Please indicate whether you will provide the appropriate medical follow-up for the client ☐ Yes ☐ No

Please indicate if you are referring this client for an eating disorder ☐ Yes ☐ No

Mental Health Treatment Plan

Mental Health	Required prior to or at sessions 10, 20, 30 & Discharge of ED psychotherapy treatment
Psychiatric or Paediatric Review	Note: Required in addition to GP review to access sessions 21-40. Consider referring early to prevent wait for client.

For clients under 16 years (signed consent required by parent/guardian):

Parent/Guardian name: _____

Parent/Guardian signature: _____

Please fax completed referral form to Dr Alissa Knight at The Calming Suite on (08) 84711010

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